LETTERS TO THE EDITOR

Lymphatic filariasis—lest we forget

EDITOR,—Lymphatic filariasis is characterised by a wide range of clinical manifestations. In a non-endemic area the diagnosis may be missed unless the index of suspicion is high.

An 18 year old sexually active male presented with a progressively increasing painless nodular swelling in the right inguinal region of 4 months' duration. The patient had an unprotected vaginal contact with a commercial sex worker 6 months earlier. There was no history of genital ulcer or urethral discharge. The general health of the patient was preserved. Examination revealed enlarged right inguinal and external iliac lymph nodes, 1–3 cm in size, firm, mobile, non-tender, and matted with normal overlying skin. Examination of genital, anal, and buccal mucosae was normal. There was no other lymphadenopathy. A differential diagnosis of lymphogranuloma venereum (LGV) and tubercular lymphadenitis was considered. Complete blood count revealed mild leucocytosis and eosinophilia. Renal and hepatic functions, urinalysis, and chest *x* ray were normal. Mantoux test and VDRL were negative. A complement fixation test for chlamydia group specific antibody was negative. Fine needle aspiration cytology from the nodes revealed reactive hyperplasia with occasional giant cells and microfilariae of *Wuchereria bancrofti*. Nocturnal blood samples for microfilariae were negative.

The patient was given diethylcarbamazine 100 mg thrice daily for 2 weeks. The lymph nodes regressed and no relapse was observed in 6 months of follow up.

The differential diagnosis of inguinal lymphadenopathy in a sexually active male includes syphilis, genital herpes, chancroid, LGV, pyogenic adenitis, tuberculosis, and lymphoma.[1] In the present case a diagnosis of LGV was considered in view of a history of sexual contact, painless and non-suppurative lymphadenopathy not apparently preceded by a genital ulcer.

Demonstration of microfilariae was decisive in clinching the diagnosis of filariasis which was not considered in the differential diagnosis. Presentation with inguinal lymphadenopathy is a feature common to both LGV and filariasis. The most frequent manifestation of secondary stage of LGV in men is unilateral inguinal lymphadenopathy which does not suppurate in two thirds of cases.[1] Iliac lymphadenopathy often develops in LGV as was observed in our patient.[2] Painful enlargement of inguinal lymph nodes with fever is the usual presentation in lymphatic filariasis. Lymphangitis can accompany recurrent attacks. Other complications include orchitis, funiculitis, and epididymitis.[3 4] These were, however, absent in our patient. It is suggested that lymphatic filariasis should be considered in differential diagnosis of inguinal lymphadenopathy even in areas which are not known to be endemic for it. It is otherwise likely to be missed.

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Canary to sparrow; what is in a name?

EDITOR,—The Contagious Diseases Act of 1864 allowed for the compulsory arrest, examination, and treatment of women considered (by an all male board) to be of loose morals. Women were detained in the so called "Canary wards" and their identity made clear by the bright yellow garments they were made to wear.

In the year 2000, there is still perceived stigma and blame associated with the diagnosis of sexually transmitted infections (STIs) and this must be minimised if a screening programme for chlamydia is to be successful. It will help reduce stigma if people know and accept that it is not a disease of a few readily identifiable people but that it is common and easy to acquire. It has been estimated that one in 14 young people will acquire it at some time.

In the NHS chlamydia pilot screening programme in Wirral and Portsmouth we are confirming that this infection is indeed endemic. Information material for the pilot study clearly states that it is a very common infection. To reduce the element of blame, we have included testing of men in some settings and have introduced instead of sexually transmitted, the term "sexually shared infection."

We hope that by measures such as these, young people will avoid stigmatisation as "canaries."

We do not, however, suggest that you change the name of your journal again!

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Acceptability of home screening for chlamydial infection: some remaining issues

EDITOR,—In the recent article by Stephenson *et al*[1] the authors describe participation rates of 39% for women and 46% for men for home screening and comment "that this might form a useful component of a community based chlamydial screening programme in which non-responders could be offered opportunistic screening at the general practice." However, certain crucial issues remain unanswered. This acceptability survey was done among women aged 18–25 years and men 18–30 years. What happens with people below the age of 18? We know that *Chlamydia trachomatis* prevalence is associated with young age, but can we also send home screening kits to 15 year olds? What about the parental opinions and legal implications—for example, for the partner of a *C trachomatis* positive youngster?

In two surveys performed in general practice in Amsterdam, Netherlands, using systematic and opportunistic screening, prevalence was strongly associated with young age but also with ethnicity. Among young Surinam-Antillian women aged <25 years, prevalences ranged from 5.4% in the systematic survey up to 22.4% in the opportunistic survey.[2 3] In the systematic survey an unexpectedly high *C trachomatis* prevalence of 10% was found among young Surinam-Antillian men. Among the 15–19 year olds visiting our health centre in Amsterdam which is located in a multiethnic neighbourhood, half of the population having a Surinam-Antillian background, *C trachomatis* prevalence was 25%.[4]

Thus, the question is not only how acceptable home screening is for the youngest age group, who might be most at risk, but also how acceptable home testing is for people with different ethnic backgrounds and people living in low socioeconomic status and high risk environments.

We piloted a pharmacy assisted approach offering urine home testing to all sexually active women age 15–30 years who come to our pharmacy to collect their contraceptives. Since the start 4 months ago 189 people received an information leaflet and home test package together with their contraceptives. Fifty nine participated and sent their urine; four were positive (6.7%).[5] The participation rate was 31%, lower than the reported rate for women in the article of Stephenson *et al*.

The assumption by the authors that people who do not participate for home screening will turn up for opportunistic screening at the general practice is, however, merely a hypothesis, and not a strong one, especially not for boys and men.

Tackling issues like risk perception and risk environment and changing healthcare seeking behaviours is not an easy task. Moreover, a community based *C trachomatis* prevention programme will require not only secondary prevention by active case finding but also primary prevention. What is needed is an integrated set of strategies, which are mutually reinforcing and that are age, sex, culture, and context specific. Quite a challenge!

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